RULES
OF
TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE
INSURANCE DIVISION

CHAPTER 0780-01-61
LONG-TERM CARE INSURANCE

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0780-01-61-.01 PURPOSE.

The purpose of these rules is to implement T.C.A. §§ 56-42-101, *et seq*., to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Authority: *T.C.A. §§ 56-42-102 and 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.02 AUTHORITY.

These rules are issued pursuant to the authority vested in the Commissioner under T.C.A. §§ 56-42-101, *et seq.*

(Rule 0780-01-61-.02, continued)
Authority: *T.C.A. §§ 56-42-102 and 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.03 APPLICABILITY AND SCOPE.

(1) Except as otherwise specifically provided, this rule applies to all long-term care insurance policies, including qualified long-term care contracts and life insurance policies that accelerate benefits for long-term care, delivered or issued for delivery in this state on or after the effective date of these rules by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations. Certain provisions of this rule apply only to qualified long-term care insurance contracts as noted.

(2) Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:

(a) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(b) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(c) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.04 DEFINITIONS.

(1) In the event the definitions in these rules and T.C.A. §§ 56-42-101, *et seq.*, conflict, the definitions in the statute control.

(2) "Applicant" means:

(a) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(b) In the case of a group long-term care insurance policy, the proposed certificate holder.

(3) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(4) "Commissioner" means the commissioner of commerce and insurance.

(5) (a) "Exceptional increase" means only those increases filed by an insurer as exceptional for which the Commissioner determines the need for the premium rate increase is justified:

1. Due to changes in laws or regulations applicable to long-term care coverage in this state; or

2. Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(Rule 0780-01-61-.04, continued)

(b) Except as provided in Rule 0780-1-61-.20, exceptional increases are subject to the same requirements as other premium rate schedule increases.

(c) The Commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

(d) The Commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

(6) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(a) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations;

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

1. Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

2. Has been maintained in good faith for purposes other than obtaining insurance;

(c) 1. An association or a trust or the trustee or trustees of a fund established, created or maintained for the benefit of members of one (1) or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of one hundred (100) persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance, have been in active existence for at least one (1) year; and have a constitution and bylaws which provide that:

(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees;

2. Thirty (30) days after such filing, the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements; or

(d) A group other than as described in Paragraphs (5)(a) through (5)(c) of this rule, subject to a finding by the Commissioner that:

1. The issuance of the group policy is not contrary to the best interest of the public;

(Rule 0780-01-61-.04, continued)

2. The issuance of the group policy would result in economies of acquisition or administration; and

3. The benefits are reasonable in relation to the premiums charged.

(7) "Incidental," as used in Rule 0780-1-61-.20(10), means that the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

(8) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes group and individual policies or riders whether issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization. "Long-term care insurance" does not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

(9) "Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

(10) "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

(11) "Qualified actuary" means a member in good standing of the American Academy of Actuaries.

(12) (a) "Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

2. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(Rule 0780-01-61-.04, continued)

3. The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986, as amended.

4. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in Paragraph (12)(a)5. of this rule.

5. All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

6. The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986, as amended.

(b) "Qualified long-term care insurance contract" or "federally tax-qualified long term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986, as amended.

(13) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in this rule are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.05 POLICY DEFINITIONS.

(1) No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

(a) "Activities of daily living" means at least bathing, continence, dressing, eating, toileting and transferring.

(b) "Acute condition" means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(c) "Adult day care" means a program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

(d) "Bathing" means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

(Rule 0780-01-61-.05, continued)

(e) "Cognitive impairment" means a deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

(f) "Continence" means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(g) "Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(h) "Eating" means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(i) "Hands-on assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

(j) "Home health care services" means medical and non-medical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

(k) "Medicare" means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof, or words of similar import.

(l) "Mental or nervous disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

(m) "Personal care" means the provision of hands-on services to assist an individual with activities of daily living.

(n) "Skilled nursing care," "intermediate care," "personal care," "home care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

(o) "Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(p) "Transferring" means moving into or out of a bed, chair or wheelchair.

(q) All providers of services, including but not limited to "skilled nursing facility," "extended care facility," "intermediate care facility," "convalescent nursing home," "personal care facility," and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.06 POLICY PRACTICES AND PROVISIONS.

(1) Renewability. The terms “guaranteed renewable” and “non-cancelable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Rule 0780-1-61-.09.

(a) No such policy issued to an individual shall contain renewal provisions less favorable to the insured than “guaranteed renewable.” However, the Commissioner may authorize non-renewal on a statewide basis, on terms and conditions deemed necessary by the Commissioner, to best protect the interest of the insureds, if the insurer demonstrates:

1. That renewal will jeopardize the insurer’s solvency; or

2. That:

(i) The actual paid claims and expenses have substantially exceeded the premium and investment income associated with the policies;

(ii) The policies will continue to experience substantial and unexpected losses over their lifetime;

(iii) The projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and

(iv) The insurer has made repeated and good faith attempts to stabilize loss experience of the policies, including the timely filing for rate adjustments.

(b) The term “guaranteed renewable” may be used when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(c) The term “non-cancelable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

(d) The term “level premium” may only be used when the insurer does not have the right to change the premium.

(e) In addition to the other requirements of this rule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(l)(C) of the Internal Revenue Code of 1986, as amended.

(2) Limitations and Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(a) Preexisting conditions or diseases.

(b) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer’s disease.

(Rule 0780-01-61-.06, continued)

(c) Alcoholism and drug addiction.

(d) Illness, treatment or medical condition arising out of:

1. War or act of war (whether declared or undeclared);

2. Participation in a felony, riot or insurrection;

3. Service in the armed forces or units auxiliary thereto;

4. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or

5. Aviation (this exclusion applies only to non-fare-paying passengers).

(e) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered persons immediate family and services for which no charge is normally made in the absence of insurance.

(f) Expenses for services or items available or paid under another long-term care insurance or health insurance policy.

(g) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

(h) This paragraph is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

(3) Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

(4) Continuation or Conversion.

(a) Group long-term care insurance issued in this state on or after the effective date of this rule shall provide covered individuals with a basis for continuation or conversion of coverage.

(b) For the purposes of this rule, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The Commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(c) For the purposes of this rule, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability.

(d) For the purposes of this rule, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and/or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

(e) Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

(f) Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

(g) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

1. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

2. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage:

(i) Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

(ii) The premium for which is calculated in a manner consistent with the requirements of subparagraph (f) of this rule.

(h) Notwithstanding any other provision of this rule, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy,

(Rule 0780-01-61-.06, continued)

would result in payment of more than one hundred percent (100%) of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

(i) The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

(j) Notwithstanding any other provision of this rule, an insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

(k) For the purposes of this rule a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

(5) Discontinuance and Replacement.

(a) If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

1. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

2. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services.

(6) Premiums.

(a) The premium charged to an insured shall not increase due to either:

1. The increasing age of the insured at ages in excess of sixty-five (65); or

2. The duration the insured has been covered under the policy.

(b) The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Rule 0780-1-61-.26, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

(c) A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Rule 0780-1-61-.26, the initial annual premium shall be based on the reduced benefits.

(7) Electronic Enrollment for Group Policies.

(a) In the case of a group as defined in this Chapter, any requirement that a signature of an insured be obtained by an insurance producer or insurer shall be deemed satisfied if:

(Rule 0780-01-61-.06, continued)

1. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

2. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention and prompt retrieval of records; and

3. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and privileged information is maintained.

(b) The insurer shall make available upon request of the Commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.07 UNINTENTIONAL LAPSE.

(1) Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(a) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one (1) person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice." The insurer shall notify the insured of the right to change this written designation, no less often than once every two (2) years.

(b) When the policyholder or certificate holder pays the premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in Paragraph (1) of this rule need not be met until sixty (60) days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (1)(a) above, at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first class United States mail, postage prepaid; and notice may not be given until thirty (30) days after a premium is due and

(Rule 0780-01-61-.07, continued)

unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

(2) Reinstatement. In addition to the requirement in Paragraph (1) of this rule, a long-term care insurance policy or certificate shall include a provision that provides for reinstatement of coverage, in the event of lapse, if the insurer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the grace period contained in the policy expired. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity contained in the policy and certificate.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.08 REQUIRED DISCLOSURE PROVISIONS.

(1) Renewability. Individual long-term care insurance policies shall contain a renewability provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or non-cancelable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

(2) A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

(3) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement.

(4) Payment of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage.

(5) Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations.”

(6) Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in T.C.A. § 56-42-105 shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits.”

(7) Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of

(Rule 0780-01-61-.08, continued)

application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This paragraph shall not apply to qualified long-term care insurance contracts.

(8) Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for long term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers shall also be explained in this section. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified.

(9) A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage in the same format as contained in Appendix H of this Chapter that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

(10) A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage in the same format as contained in Appendix H of this Chapter that the policy is not intended to be a qualified long-term care insurance contract.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.09 REQUIRED DISCLOSURE OF RATING PRACTICES TO CONSUMERS.

(1) This rule shall apply as follows:

(a) Except as provided in Paragraph (1)(b) of this rule, this rule applies to any long-term care policy or certificate issued in this state on or after six (6) months after the effective date of this rule.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in this Chapter, which policy was in force at the time this amended rule became effective, the provisions of this rule shall apply on the policy anniversary following twelve (12) months after the effective date of this rule.

(2) Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this paragraph to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the following information to the applicant no later than at the time of delivery of the policy or certificate:

(a) A statement that the policy may be subject to rate increases in the future.

(b) An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision.

(c) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase.

(d) A general explanation for applying premium rate or rate schedule adjustments that shall include:

(Rule 0780-01-61-.09, continued)

1. A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

2. The right to a revised premium rate or rate schedule as provided in Paragraph (2)(c) of this rule if the premium rate or rate schedule is changed.

(e) 1. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state that, at a minimum, identifies:

(i) The policy forms for which premium rates have been increased;

(ii) The calendar years when the form was available for purchase; and

(iii) The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

2. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

3. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

4. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this rule or the end of a twenty-four (24) month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Paragraph (2)(a) of this rule.

5. If the acquiring insurer in Paragraph (2)(e)4. of this rule files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph 4. of this rule, the acquiring insurer must make all disclosures required by Paragraph (5) of this rule, including disclosure of the earlier rate increase referenced in Paragraph (2)(d) of this rule.

(3) An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required by this rule. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(4) An insurer shall use the forms in Appendices D and I of this Chapter to comply with the requirements of this rule.

(5) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least forty-five (45) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Paragraph (2) of this rule when the rate increase is implemented.

(Rule 0780-01-61-.09, continued)

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.10 INITIAL FILING REQUIREMENTS.

(1) This rule applies to any long-term care policy issued in this state on or after six (6) months after the effective date of these rules.

(2) An insurer shall provide the information listed in this paragraph to the Commissioner at least thirty (30) days prior to making a long-term care insurance form available for sale.

(a) A copy of the disclosure documents required in Rule 0780-61-.09; and

(b) An actuarial certification consisting of at least the following:

1. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

2. A statement that the policy design and coverage provided have been reviewed and taken into consideration;

3. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

4. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

(I) An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(II) If the gross premiums for certain age groups appear to be inconsistent with this requirement, the Commissioner may request a demonstration under Paragraph (3) of this rule based on a standard age distribution; and

5. (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(Rule 0780-01-61-.10, continued)

(ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(3) (a) The Commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

(b) In the event the Commissioner asks for additional information under this provision, the period in Paragraph (2) of this rule does not include the period during which the insurer is preparing the requested information.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.11 PROHIBITION AGAINST POST-CLAIMS UNDERWRITING.

(1) All applications for long-term care insurance policies or certificates except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(2) (a) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(b) If the medications listed in the application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(3) Except for policies or certificates which are guaranteed issue:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address].

(c) Prior to issuance of a long-term care policy or certificate to an applicant age eighty (80) or older, the insurer shall obtain one of the following:

1. A report of a physical examination;

(Rule 0780-01-61-.11, continued)

2. An assessment of functional capacity;

3. An attending physician's statement; or

4. Copies of medical records.

(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application.

(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those that the insured voluntarily effectuated and shall annually furnish this information to the Commissioner in the form set forth in Appendix C to this Chapter.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.12 MINIMUM STANDARDS FOR HOME HEALTH AND COMMUNITY CARE BENEFITS IN LONG-TERM CARE INSURANCE POLICIES.

(1) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:

(a) By requiring that the insured or claimant would need skilled care in a skilled nursing facility if home health care services were not provided;

(b) By requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services, or both, in a home, community or institutional setting before home health care services are covered;

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses;

(d) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

(e) By excluding coverage for personal care services provided by a home health aide;

(f) By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(g) By requiring that the insured or claimant have an acute condition before home health care services are covered;

(h) By limiting benefits to services provided by Medicare-certified agencies or providers; or

(i) By excluding coverage for adult day care services.

(2) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care

(Rule 0780-01-61-.12, continued)

services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(3) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.13 REQUIREMENT TO OFFER INFLATION PROTECTION.

(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one (1) of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than five percent (5%);

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent (5%) for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) Where the policy is issued to a group, the required offer in Paragraph (1) of this rule shall be made to the group policyholder; except, if the policy is issued to a group as defined in this Chapter other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(3) The offer in Paragraph (1) of this rule shall not be required of life insurance policies or riders containing accelerated long-term care benefits, nor expense incurred long-term care insurance policies.

(4)

(a) Insurers shall include the following information in or with the outline of coverage:

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages seventy-five (75) and eighty-five (85) for benefit increases.

(Rule 0780-01-61-.13, continued)

(b) An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(7) Inflation protection as provided in Paragraph (1)(a) of this rule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this rule. The rejection may be either in the application or on a separate form The rejection shall be considered a part of the application and shall state:

"I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans ____, and I reject inflation protection."

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.14 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

(1) Questions Concerning Replacement. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an insurance producer, containing the questions may be used. With regard to a replacement policy issued to a group as defined by this Chapter, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced, provided that the certificate-holder has been notified of the replacement.

(a) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(b) Did you have another long-term care insurance policy or certificate in force during the last twelve (12) months?

1. If so, with which company?

2. If that policy lapsed, when did it lapse?

(c) Are you covered by TennCare?

(d) Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

(2) Insurance producers shall list any other health insurance policies they have sold to the applicant.

(Rule 0780-01-61-.14, continued)

(a) List policies sold that are still in force.

(b) List policies sold in the past five (5) years that are no longer in force.

(3) Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its insurance producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be identical or substantially similar to the Notice provided in Appendix A of this Chapter.

(4) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Notice shall be made within five (5) working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(5) Life insurance policies that accelerate benefits for long-term care shall comply with this rule if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of Tennessee Code Annotated, Title 56. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

(6) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be identical or substantially similar to the Notice provided in Appendix B of this Chapter.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.15 REPORTING REQUIREMENTS.

(1) Every insurer shall maintain records for each insurance producer of that insurance producer's amount of replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales.

(2) Every insurer shall report annually by June 30 the ten percent (10%) of its insurance producers with the greatest percentages of lapses and replacements as measured by Paragraph (1) of this rule. The insurer shall use the form as set out in Appendix J of this Chapter.

(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely insurance producer activities regarding the sale of long-term care insurance.

(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year. The insurer shall use the form as set out in Appendix J of this Chapter.

(Rule 0780-01-61-.15, continued)

(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year. The insurer shall use the form as set out in Appendix J of this Chapter.

(6) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied. The insurer shall use the form as set out in Appendix G of this Chapter.

(7) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate recissions, both state and nationwide, except those initiated by the insured and shall annually furnish this information to the Commissioner in the format as set out in Appendix C of this Chapter.

(8) For purposes of this rule:

(a) "Policy" means only long-term care insurance;

(b) Subject to Paragraph (8)(c) of this rule, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

(c) "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

(d) "Report" means on a statewide basis.

(9) Reports required under this rule shall be filed with the Commissioner.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.16 LICENSING.

A producer is not authorized to sell, solicit or negotiate with respect to long-term care insurance except as authorized by T.C.A. §§ 56-6-101, *et seq*.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 20, 1991; effective August 4, 1991. Repeal and new rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.17 DISCRETIONARY POWERS OF COMMISSIONER.

(1) The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this Chapter with respect to a specific long-term care insurance policy or certificate upon a written finding that:

(a) The modification or suspension would be in the best interest of the insureds;

(b) The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

(c) 1. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care;

(Rule 0780-01-61-.17, continued)

2. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

3. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance product.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.18 RESERVE STANDARDS.

(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life insurance policies or riders to such policies, policy reserves for the benefits shall be determined in accordance with T.C.A. § 56-1-403. Claim reserves shall also be established in the case when the policy or rider is in claim status.

Reserves for policies and riders subject to this rule should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this rule, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

(a) Definition of insured events;

(b) Covered long-term care facilities;

(c) Existence of home convalescence care coverage;

(d) Definition of facilities;

(e) Existence or absence of barriers to eligibility;

(f) Premium waiver provision;

(g) Renewability;

(h) Ability to raise premiums;

(i) Marketing method;

(j) Underwriting procedures;

(k) Claims adjustment procedures;

(l) Waiting period;

(Rule 0780-01-61-.18, continued)

(m) Maximum benefit;

(n) Availability of eligible facilities;

(o) Margins in claim costs;

(p) Optional nature of benefit;

(q) Delay in eligibility for benefit;

(r) Inflation protection provisions; and

(s) Guaranteed insurability option.

(2) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.19 LOSS RATIO.

(1) This rule shall apply to all long term care insurance policies or certificates except those covered under Rules 0780-1-61-.10 and 0780-1-61-.20.

(2) Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums;

(b) The period for which rates are computed to provide coverage;

(c) Experienced and projected trends;

(d) Concentration of experience within early policy duration;

(e) Expected claim fluctuation;

(f) Experience refunds, adjustments or dividends;

(g) Renewability features;

(h) All appropriate expense factors;

(i) Interest;

(j) Experimental nature of the coverage;

(k) Policy reserves;

(l) Mix of business by risk classification; and

(Rule 0780-01-61-.19, continued)

(m) Product features such as long elimination periods, high deductibles and high maximum limits.

(3) Paragraph (2) of this rule shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of T.C.A. § 56-7-401.

(c) The policy meets the disclosure requirements of T.C.A. § 56-42-105(i); and

(d) An actuarial memorandum is filed with the Department of Commerce and Insurance that includes:

1. A description of the basis on which the long-term care rates were determined;

2. A description of the basis for the reserves;

3. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

4. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

6. The estimated average annual premium per policy and the average issue age;

7. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

8. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.20 PREMIUM RATE SCHEDULE INCREASES.

(1) This rule shall apply as follows:

(Rule 0780-01-61-.20, continued)

(a) Except as provided in Paragraph (1)(b), this rule applies to any long-term care policy or certificate issued in this state on or after six (6) months after the effective date of these rules.

(b) For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in this Chapter, which policy was in force at the time this amended rule became effective, the provisions of this paragraph shall apply on the policy anniversary following twelve (12) months after the effective date of this rule.

(2) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Commissioner at least thirty (30) days prior to the notice to the policyholders and shall include:

(a) Information required by Rule 0780-1-61-.09;

(b) Certification by a qualified actuary that:

1. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

2. The premium rate filing is in compliance with the provisions of this rule;

(c) An actuarial memorandum justifying the rate schedule change request that includes:

1. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale.

(i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;

(ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) The projections shall demonstrate compliance with Paragraph (3) of this rule; and

(iv) For exceptional increases,

(I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and

(II) In the event the Commissioner determines as provided in Rule 0780-1-61-.04(5)(d) that offsets may exist, the insurer shall use appropriate net projected experience;

2. Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

3. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

4. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

5. In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

(d) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the Commissioner; and

(e) Sufficient information for review and approval of the premium rate schedule increase by the Commissioner.

(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

(a) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

(b) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

1. The accumulated value of the initial earned premium times fifty-eight percent (58%);

2. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;

3. The present value of future projected initial earned premiums times fifty-eight percent (58%); and

4. Eighty-five percent (85%) of the present value of future projected premiums not in Paragraph (3)(b)3. of this rule on an earned basis.

(c) In the event that a policy form has both exceptional and other increases, the values in Paragraphs (3)(b)2. and (3)(b)4. of this rule will also include seventy percent (70%) for exceptional rate increase amounts.

(4) For each rate increase that is implemented, the insurer shall file for approval by the Commissioner updated projections, as defined in Paragraph (2)(c)1. of this rule, annually for the next three (3) years and include a comparison of actual results to projected values. The Commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Paragraph (11) of this rule, the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the Commissioner.

(5) If any premium rate in the revised premium rate schedule is greater than two hundred (200%) percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Paragraph (2)(c)1. of this rule, shall be filed for approval by the Commissioner every five (5) years following the end of the required period in Paragraph (4) of this rule. For group insurance policies that meet the conditions in Paragraph (11) of this rule, the

(Rule 0780-01-61-.20, continued)

projections required by this paragraph shall be provided to the policyholder in lieu of filing with the Commissioner.

(6) (a) If the Commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Paragraph (3) of this rule, the Commissioner may require the insurer to implement any of the following:

1. Premium rate schedule adjustments; or

2. Other measures to reduce the difference between the projected and actual experience.

(b) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Paragraph (2)(c)5. of this rule, if applicable.

(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(a) A plan, subject to Commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the Commissioner may impose the condition in Paragraph (8) of this rule; and

(b) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Paragraph (3) of this rule had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Paragraphs (3)(b)1. and (3)(b)3. of this rule.

(8) (a) For a rate increase filing that meets the following criteria, the Commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

1. The rate increase is not the first rate increase requested for the specific policy form or forms;

2. The rate increase is not an exceptional increase; and

3. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(b) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the Commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the Commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

1. The offer shall:

(Rule 0780-01-61-.20, continued)

(i) Be subject to the approval of the Commissioner;

(ii) Be based on actuarially sound principles, but not be based on attained age; and

(iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

2. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(i) The maximum rate increase determined based on the combined experience; and

(ii) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

(9) If the Commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the Commissioner may, in addition to the provisions of Paragraph (8) of this rule, prohibit the insurer from either of the following:

(a) Filing and marketing comparable coverage for a period of up to five (5) years; or

(b) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(10) Paragraphs (1) through (9) of this rule shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Rule 0780-1-61-.04(7), if the policy complies with all of the following provisions:

(a) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(b) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements in T.C.A. § 56-7-401.

(c) The policy meets the disclosure requirements of T.C.A. § 56-42-105(i).

(d) An actuarial memorandum is filed with the Department of Commerce and Insurance that includes:

1. A description of the basis on which the long-term care rates were determined;

2. A description of the basis for the reserves;

3. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

4. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(Rule 0780-01-61-.20, continued)

5. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

6. The estimated average annual premium per policy and the average issue age;

7. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

8. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(11) Paragraphs (6) and (8) of this rule shall not apply to group insurance policies as defined in this Chapter where:

(a) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

(b) The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.21 FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to T.C.A. § 56-42-104, it shall file with the Commissioner evidence that the group policy or certificate hereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.22 FILING REQUIREMENTS FOR ADVERTISING.

(1) Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio or television medium to the Commissioner for review or approval by the Commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three (3) years from the date the advertisement was first used.

(2) The Commissioner may exempt from these requirements any advertising form or material when, in the Commissioner's opinion, this requirement may not be reasonably applied.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.23 STANDARDS FOR MARKETING.

(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(a) Establish marketing procedures and insurance producer training requirements.

1. Any marketing activities, including any comparison of policies by its insurance producers or other producers will be fair and accurate; and

2. Excessive insurance is not sold or issued.

(b) Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(c) Provide copies of the disclosure forms as required by Rule 0780-1-61-.09 to the applicant.

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.

(e) Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with Paragraph (1) of this rule.

(f) If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the Commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that the program is available and the name, address and telephone number of the program.

(g) For long-term care insurance policies and certificates, use the terms "non-cancelable" or "level premium" only when the policy or certificate conforms to Rule 0780-1-61-.06(1)(c).

(h) Provide copies of the disclosure forms required in Rule 0780-1-61-.09 and to the applicant.

(i) Provide an explanation of contingent benefit upon lapse provided for in Rule 0780-1-61-.26(6).

(2) In addition to the practices prohibited in T.C.A. §§ 56-8-101, *et seq.*, the following acts and practices are prohibited:

(a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(Rule 0780-01-61-.23, continued)

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(c) Cold lead advertising. Making use, directly or indirectly, of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

(d) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

(3) (a) With respect to the obligations set forth in this paragraph, the primary responsibility of an association, as defined in T.C.A. § 56-42-103, when endorsing or selling long-term care insurance, shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(b) The insurer shall file with the Commissioner the following material:

1. The policy and certificate,

2. A corresponding outline of coverage, and

3. All advertisements requested by the Department of Commerce and Insurance.

(c) The association shall disclose in any long-term care insurance solicitation:

1. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and

2. A brief description of the process under which the policies and the insurer issuing the policies were selected.

(d) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(e) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(f) The association shall also:

1. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change.

2. Actively monitor the marketing efforts of the insurer and its insurance producer.

(Rule 0780-01-61-.23, continued)

3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

4. Subparts 1. through 3. of this subparagraph shall not apply to qualified long-term care insurance contracts.

(g) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the Commissioner the information required in this rule.

(h) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this rule.

(i) Failure to comply with the filing and certification requirements of this rule constitutes an unfair trade practice in violation of T.C.A. §§ 56-8-101, *et seq.*

Authority: *T.C.A. §§ 56-6-124, 56-8-104(1), 56-8-113, 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.24 SUITABILITY.

(1) This rule shall not apply to life insurance policies that accelerate benefits for long-term care.

(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

(a) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

(b) Train its insurance producers in the use of its suitability standards; and

(c) Maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.

(3) (a) To determine whether the applicant meets the standards developed by the issuer, the insurance producer and issuer shall develop procedures that take the following into consideration:

1. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

2. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

3. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

(b) The issuer, and where an insurance producer is involved, the insurance producer, shall make reasonable efforts to obtain the information set out in Paragraph (3)(a) of this rule. The efforts shall include presentation to the applicant, at or prior to application, of the Long-Term Care Insurance Personal Worksheet as set forth in Appendix D to this Chapter. The personal worksheet used by the issuer shall contain, at a minimum, the information in the sample made Appendix D to this Chapter, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to

(Rule 0780-01-61-.24, continued)

comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Commissioner.

(c) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

(d) The sale or dissemination outside the company or agency by the issuer or insurance producer, of information obtained through the Long-Term Care Insurance Personal Worksheet is prohibited.

(4) The issuer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

(5) Insurance producers shall use the suitability standards developed by the issuer in marketing long-term care insurance on behalf of the issuer.

(6) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled, "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. All such disclosure forms shall be identical to the sample format made Appendix E to this Chapter, in not less than twelve (12) point type.

(7) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the letter in Appendix F to this Chapter. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

(8) The issuer shall report annually to the Commissioner the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.25 PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONERY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.26 NONFORFEITURE BENEFIT REQUIREMENT.

(1) This rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(Rule 0780-01-61-.26, continued)

(2) Except as provided in Paragraph (3) of this rule, a long-term care policy may not be delivered or issued for delivery in this state unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificateholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(3) When a group long-term care insurance policy is issued, the offer required in Paragraph (2) of this rule shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in this Chapter, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

(4) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Paragraph (7) of this rule and the offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

(5) If the offer required to be made is rejected, the insurer shall provide the contingent benefit upon lapse described in this rule.

(6) (a) After rejection of the offer, for individual and group policies without nonforfeiture benefits issued after the effective date of this rule, the insurer shall provide a contingent benefit upon lapse.

(b) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(c) The contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%

(Rule 0780-01-61-.26, continued)

66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(d) On or before the effective date of a substantial premium increase as defined in Paragraph (6)(c) of this rule, the insurer shall:

1. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

2. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Paragraph (7) of this rule. This option may be elected at any time during the 120-day period referenced in Paragraph (6)(c) of this rule; and

3. Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in Paragraph (6)(c) of this rule shall be deemed to be the election of the offer to convert as referenced in Paragraph (6)(d)2 of this rule.

(7) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this paragraph:

(a) For purposes of this paragraph, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50).

(b) For purposes of this paragraph, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Paragraph (7)(c) of this rule.

(c) The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Paragraph (8) of this rule.

(d) 1. The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter.

2. Notwithstanding Paragraph (7)(d)1. for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(i) The end of the tenth (10th) year following the policy or certificate issue date; or

(ii) The end of the second (2nd) year following the date the policy or certificate is no longer subject to attained age rating.

(e) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(8) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status.

(9) There shall be no difference in the minimum nonforfeiture benefits as required under this paragraph for group and individual policies.

(10) The requirements set forth in this rule shall become effective twelve (12) months after the effective date of this rule and shall apply as follows:

(a) Except as provided in Paragraph (10)(b), the provisions of this paragraph apply to any long-term care policy issued in this state on or after the effective date of this rule.

(b) For certificates issued on or after the effective date of this rule, under a group long-term care insurance policy as defined in this Chapter, which policy was in force at the time this amended rule became effective, the provisions of this paragraph shall not apply.

(11) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the loss ratio requirements of Rule 0780-1-61-.19 treating the policy as a whole.

(12) To determine whether contingent nonforfeiture benefit upon lapse provisions are triggered under Paragraph (6)(c) of this rule, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(13) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

(Rule 0780-01-61-.26, continued)

(a) The nonforfeiture provision shall be appropriately captioned;

(b) The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Commissioner for the same contract form; and

(c) The nonforfeiture provision shall provide at least one (1) of the following:

1. Reduced paid-up insurance;

2. Extended term insurance;

3. Shortened benefit period; or

4. Other similar offerings approved by the Commissioner.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.27 STANDARDS FOR BENEFIT TRIGGERS.

(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment.

(2) (a) Activities of daily living shall include at least the following, as defined in Rule 0780-1-61-.05 and in the policy:

1. Bathing;

2. Continence;

3. Dressing;

4. Eating;

5. Toileting; and

6. Transferring.

(b) Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Paragraph (2)(a) of this rule as long as they are defined in the policy.

(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Paragraphs (1) and (2) of this rule.

(4) For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

(a) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

(Rule 0780-01-61-.27, continued)

(b) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

(6) Long term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

(7) The requirements set forth in this rule shall be effective twelve (12) months after the effective date of this rule and shall apply as follows:

(a) Except as provided in subparagraph (b) of this paragraph, the provisions of this rule apply to a long-term care policy issued in this state on or after the effective date of the rule.

(b) For certificates issued on or after the effective date of this paragraph, under a group long-term care insurance policy as defined in this Chapter that was in force at the time this amended rule became effective, the provisions of this paragraph shall not apply.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.28 ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(1) For purposes of this rule the following definitions apply:

(a) "Qualified long-term care services" means services that meet the requirements of Section 7702B(c)(l) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(b) 1. "Chronically ill individual" has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as:

(i) Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or

(ii) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

2. The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements.

(c) "Licensed health care practitioner" means a physician, as defined in 42 USC 1395x(r), a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

(Rule 0780-01-61-.28, continued)

(d) "Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

(2) A qualified long term care insurance contract shall pay only for qualified long term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity or to severe cognitive impairment.

(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to Paragraph (3) of this rule shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet the requirements prescribed by the Secretary of the Treasury.

(5) Certifications required pursuant to Paragraph (3) of this rule may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety-day period.

(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.29 STANDARD FORMAT OUTLINE OF COVERAGE.

(1) This paragraph implements, interprets and makes specific, the provisions of T.C.A. § 56-42-105(g) in prescribing a standard format and the content of an outline of coverage.

(a) The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

(b) The outline of coverage shall contain no material of an advertising nature.

(c) Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring.

(d) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

(e) All outlines of coverage used in this state shall be in a format identical or substantially similar to the sample format in Appendix H to this Chapter.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original rule filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.30 REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(a) In the case of insurance producer solicitations, an insurance producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

Authority: *T.C.A. § 56-42-105.* ***Administrative History:*** *Original filed June 15, 2005; effective August 29, 2005.*

0780-01-61-.31 LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM.

(1) In accordance with Section 6021 of the Deficit Reduction Act of 2005 (Pub.L. 109-171) and in addition to the applicable provisions of this Chapter, the provisions of this Rule shall apply to any Qualified State Long-Term Care Insurance Partnership Policy.

(2) As used in this Rule, "Qualified State Long-Term Care Insurance Partnership Policy" or "Partnership Policy" means an insurance policy that:

(a) Covers an insured who was a resident of Tennessee, or another state that has a Partnership Program, when coverage first became effective under the policy;

(b) Is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than February 8, 2006;

(c) Meets all the applicable requirements of this Chapter and the requirements of the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Model Regulation as those requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)); and

(d) Provides the following inflation protections:

1. For a person who is less than sixty-one (61) years of age as of the date of purchase of the policy, the policy provides compound annual inflation protection;

2. For a person who is at least sixty-one (61) years of age but less than seventy-six (76) years of age as of the date of purchase of the policy, the policy provides some level of inflation protection; and

3. For a person who is at least seventy-six (76) years of age as of the date of purchase of the policy, the policy may provide inflation protection, but is not required.

(3) (a) An insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a Partnership Policy, shall provide to each prospective applicant a Long-Term Care Insurance Partnership Program Notice in a form identical to or substantially similar to Appendix K, outlining the requirements and benefits of a partnership policy. A similar notice may be used for this purpose if filed and approved by the commissioner. The Partnership Program Notice shall be provided with the required Outline of Coverage.

(Rule 0780-01-61-.31, continued)

(b) An insurer or its agent, soliciting or offering to sell a policy that is intended to qualify as a Partnership Policy, shall provide to each prospective applicant a pamphlet approved by the Commissioner that explains rules regarding Medicaid eligibility. Copies of the pamphlet can be accessed through request to the Department or on the Department's web site.

(c) A Partnership Policy issued or issued for delivery in Tennessee shall be accompanied by a Long-Term Care Insurance Partnership Disclosure Notice in a form identical to or substantially similar to Appendix L explaining the benefits associated with a Partnership Policy and indicating that at the time issued, the policy is a Qualified State Long-Term Care Insurance Partnership Policy. A similar notice may be used if filed and approved by the Commissioner. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this Partnership Policy, the insured does not automatically qualify for Medicaid.

(4) (a) A Partnership Policy shall not be issued or issued for delivery in Tennessee unless filed with and approved by the Commissioner. Any policy submitted for certification as a Partnership Policy shall be accompanied by an Issuer Certification Form identical to Appendix M, or a similar form filed and approved by the Commissioner.

(b) A policy which was issued on or after February 8, 2006 and which otherwise satisfied all the terms and requirements to be a Partnership Policy shall be eligible for an exchange to a Partnership Policy on or after October 1, 2008. The insurer that issued such a policy shall be required to either issue a Partnership Rider amending the existing policy or exchange the existing policy for a Partnership Policy. Such rider may be issued or such exchange made only after the policy to which it pertains has been filed and approved by the Commissioner as a Partnership Policy under the process set forth in Subparagraph (4)(a) of this Rule. The insurer shall provide the insured with the same materials as those issued to the purchaser of a new policy, as provided in Paragraph (3) above.

(c) Insurers requesting to make use of a previously approved policy form as a Qualified State Long-Term Care Partnership Policy shall submit to the Commissioner an Issuer Certification Form signed by an officer of the company.

(5) (a) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer who is currently licensed to sell long term care insurance and has completed a one-time training course by or before July 1, 2009. An individual who is not licensed to sell long-term care insurance by July 1, 2008, must take the one-time training course before beginning to sell long-term care products. Individuals who are not already exempt from continuing education requirements under T.C.A. § 56-6-107(c), must also complete continuing education courses every twenty-four (24) months. The training must meet the requirements set forth in subsection (b) of this Paragraph.

(b) 1. The one-time training required by this Rule shall be no less than eight (8) hours and the ongoing training required by this Rule shall be no less than four (4) hours.

2. The training required under subdivision Paragraph (5)(b)1. shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance partnership programs, including, but not limited to:

(i) State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs

(Rule 0780-01-61-.31, continued)

and other public and private coverage of long-term care services, including Medicaid;

(ii) Available long-term services and providers;

(iii) Changes or improvements in long-term care services or providers;

(iv) Alternatives to the purchase of private long-term care insurance;

(v) The effect of inflation on benefits and the importance of inflation protection; and

(vi) Consumer suitability standards and guidelines.

3. The training required by this Rule shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law.

4. Non-resident insurance producers who meet the education and training requirements of their home state will be deemed to meet the requirements for education and training in this state.

(c) 1. Insurers subject to this Chapter shall obtain verification that a producer has received training required by this Rule before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the commissioner upon request.

2. Insurers subject to this Chapter shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the Commissioner to provide assurance to the state Medicaid agency that producers have received the training contained in this Rule and that producers have demonstrated an understanding of Partnership Policies and their relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be made available to the Commissioner upon request.

Authority: *Pub.L. 109-171, § 6021(a)(1), 42 U.S.C. § 1396p(b), T.C.A. §§ 56-6-107, 56-8-101 et seq, 56-8-104, 56-42-101, et seq, 56-42-105, 56-42-109, 56-42-110, The TN Medicaid State Plan, TN 08-001, eff. 10/1/08, and 2008 Tenn. Pub. Act Ch. 1058.* ***Administrative History:*** *Original rule filed November 24, 2008; effective February 7, 2009.*

APPENDIX A

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE [INSURANCE COMPANY NAME AND ADDRESS] SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(Rule 0780-01-61, Appendix A, continued)

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement To Applicant By Insurance producer [Broker Or Other Representative]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

The above “Notice to Applicant” was delivered to me on:

_____
(Date)

_____
(Applicant’s Signature)

APPENDIX B

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[INSURANCE COMPANY NAME AND ADDRESS]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FURTURE.

According to [your application] [information you have furnished] you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name] Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term

(Rule 0780-01-61, Appendix B, continued)

care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

Statement To Applicant By Insurance Producer [Broker Or Other Representative]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. Carefully check the application and write to [company name and address] within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

The above “Notice to Applicant” was delivered to me on:

_____
(Date)

_____
(Applicant’s Signature)

APPENDIX C

RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES
FOR THE STATE OF TENNESSEE
FOR THE REPORTING YEAR _____

Company Name: _____ NAIC Number: _____

Company Address: _____

Contact Person: _____ Phone No. _____

E-mail address:

(Rule 0780-01-61, Appendix C, continued)

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report.

Name of Insured	Policy/Certificate #	Policy Form #	Date of Policy Issuance	Date(s) Claim(s) submitted	Date of Rescission	Detailed Reason for Rescission

Signature:

_____

Name and Title Date

APPENDIX D

LONG TERM CARE INSURANCE
PERSONAL WORKSHEET

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information.

Policy Form Number(s) _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year,] [a one-time single premium of $_____.]

Type of Policy (non-cancelable/guaranteed renewable): _____

The Company's Right to Increase Premiums: _____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.

Rate Increase History.

(Rule 0780-01-61, Appendix D, continued)

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increase(s).]

The insurer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income.

How will you pay each year's premium?
☐From my Income
☐From my Savings\Investments
☐My Family will Pay

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?
☐Yes
☐No

What is your annual income?
☐Under $10,000
☐$10,000 - 20,000
☐$20,000 - 30,000
☐$30,000 - 50,000
☐Over $50,000

How do you expect your income to change over the next 10 years?
☐No change
☐Increase
☐Decrease

> If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection?
☐ Yes ☐ No

If not, how you will pay for the difference between future costs and your daily benefit amount?
☐From my Income
☐From my Savings\Investments
☐My Family will Pay

> The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

What elimination period are you considering?
Number of days _____
Approximate cost for that period of care: $_____

How are you planning to pay for your care during the elimination period?

(Rule 0780-01-61, Appendix D, continued)
☐From my Income
☐From my Savings\Investments
☐My Family will Pay

Questions Related to Your Savings and Investments.

Not counting your home, about how much are all of your assets (your savings and investments) worth?
☐Under $20,000
☐$20,000 - $30,000
☐$30,000 - $50,000
☐Over $50,000

How do you expect your assets to change over the next ten years?
☐Stay about the same
☐Increase
☐Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

DISCLOSURE STATEMENT

☐ The answers to the questions above describe my financial situation. or ☐ I choose not to complete this information.
☐ I acknowledge that the carrier and/or its insurance producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).

Signed:_____ _____
(Applicant) (Date)

☐ I explained to the applicant the importance of completing this information.

Signed:_____ _____
(Insurance producer) (Date)

Insurance producer's Printed Name: _____

(Rule 0780-01-61-.28, Appendix D, continued)

In order for us to process your application, please return this signed statement to [name of company], along with your application.

☐ My insurance producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed:_____ _____

(Applicant) (Date)

The company may contact you to verify your answers.

APPENDIX E

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance	A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future. The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	Medicare does not pay for most long-term care.
TennCare Medicaid	Your choice of long-term care services may be limited if you are receiving TennCare. To learn more about TennCare, contact the TennCare Bureau.
Shopper's Guide	Make sure the insurance company or insurance producer gives you a copy of a book called the National Association of Insurance Commissioners, "Shopper's Guide to Long-Term Care Insurance". Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
Facilities	Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the

(Rule 0780-01-61-.28, Appendix E, continued)

	policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

APPENDIX F

LONG-TERM CARE INSURANCE SUITABILITY LETTER

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.
☐ Yes, although my worksheet indicates that long-term care insurance may not be a suitable purchase, I wish to purchase this coverage. Please resume review of my application.

☐ No, I have decided not to buy a policy at this time.

Signed:

_____ _____
(Applicant's Signature) (Date)

Please return to [issuer] at [address] by [date].

APPENDIX G

CLAIMS DENIAL REPORTING FORM FOR LONG-TERM CARE INSURANCE FOR THE STATE OF TENNESSEE FOR THE REPORTING YEAR _____

Company Name: _____ NAIC Number: _____

Company Address: _____

Contact Person: _____ Phone No. _____

E-mail address: _____

Line of Business: _____Individual _____Group

Due: June 30 annually

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	Nationwide Data[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claim Denied due to:		
8	Long-Term Care Services Not Covered under the Policy[2]		
9	Provider/Facility Not Qualified under the Policy[3]		
10	Benefit Eligibility Criteria Not Met[4]		
11	Other		

Notes:

1. The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.
2. Example-home health care claim filed under a nursing home only policy.
3. Example-a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.
4. Examples-a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX H

FORMAT FOR OUTLINE OF COVERAGE FOR LONG-TERM CARE INSURANCE

[Company Name]
[Address - City & State]
[Telephone Number]
Long-Term Care Insurance
Outline Of Coverage
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [a group policy] which was issued in the [indicate jurisdiction in which group policy was issued].

2. Purpose Of Outline Of Coverage. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you Read Your Policy (Or Certificate) Carefully!

3. Federal Tax Consequences. This [policy] [certificate] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.
   OR
   Federal Tax Implications of this [policy] [certificate]. This [policy] [certificate] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. Benefits received under the [policy] [certificate] may be taxable as income.

4. Terms Under Which The Policy Or Certificate May Be Continued In Force Or Discontinued.
   (a) For long-term care health insurance policies or certificates describe one of the following permissible policy renewability provisions:
      (1) [Policies and certificates that are guaranteed renewable shall contain the following statement:] Renewability: This Policy [Certificate] Is Guaranteed Renewable. This means you have the right, subject to the terms of your policy, [certificate] to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, it may increase the premium you pay.
      (2) [Policies and certificates that are non-cancelable shall contain the following statement:] Renewability: This Policy [Certificate] Is Noncancellable. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change

(Rule 0780-01-61-.28, Appendix H, continued)

any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy.]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. Terms Under Which The Company May Change Premiums.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium, and if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. Terms Under Which The Policy Or Certificate May Be Returned And Premium Refunded.

(a) [Provide a brief description of the "right to return-free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. This Is Not Medicare Supplement Coverage. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For insurance producers] Neither [insert company name] nor its insurance producers represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. Long-Term Care Coverage. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. Benefits Provided By This Policy.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Non-institutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits [Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.] [Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified.] [If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.

10. Limitations And Exclusions. [Describe:]

(a) Preexisting conditions;

(b) Non-eligible facilities and provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a

(Rule 0780-01-61-.28, Appendix H, continued)

family member, etc.);
(d) Exclusions and exceptions;
(e) Limitations.

[This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in Number 6 above.]

This policy may not cover all the expenses associated with your long-term care needs.

11. Relationship Of Cost Of Care And Benefits. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:]
(a) That the benefit level will not increase over time;
(b) Any automatic benefit adjustment provisions;
(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;
(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;
(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.

12. Alzheimer's Disease And Other Organic Brain Disorders. [State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. Premium.
[(a) State the total annual premium for the policy;]
[(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. Additional Features.
[(a) Indicate if medical underwriting is used;]
[(b) Describe other important features.]

APPENDIX I

LONG-TERM CARE INSURANCE
POTENTIAL RATE INCREASE DISCLOSURE FORM

[Insurers shall provide all of the following information to the applicant:]

1. [Premium Rate] [Premium Rate Schedules]: [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____])

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.

3. Rate Schedule Adjustments:

(Rule 0780-01-61, Appendix I, continued)

The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. Potential Rate Revisions:

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates cannot be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

* Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

- Your "paid-up" policy benefits are $10,000 (provided you have a least $10,000 of benefits remaining under your policy.)

(Rule 0780-01-61, Appendix I, continued)

CONTINGENT NONFORFEITURE
CUMULATIVE PREMIUM INCREASE OVER INITIAL PREMIUM
THAT QUALIFIES FOR CONTINGENT NONFORFEITURE

(Percentage increase is cumulative from date of original issue. It does not represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

APPENDIX J

LONG-TERM CARE INSURANCE
REPLACEMENT AND LAPSE REPORTING FORM
FOR THE STATE OF TENNESSEE
FOR REPORTING YEAR _____

Company Name: _____ NAIC Number: _____
Company Address: _____
Contact Person: _____ Phone No. _____
E-mail address: _____
Due: June 30 annually

INSTRUCTIONS

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each insurance producer on that insurance producer's amount of long-term care insurance replacement sales as a percent of the insurance producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the insurance producer as a percent of the insurance producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's insurance producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Insurance producers with the Greatest Percentage of Replacements

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Replaced By This Insurance Producer	Number of Replacements As % of Number Sold By This Insurance Producer

Listing of the 10% of Insurance producers with the Greatest Percentage of Lapses

Insurance Producer's Name	Number of Policies Sold By This Insurance Producer	Number of Policies Lapsed By This Insurance Producer	Number of Lapses As % of Number Sold By This Insurance Producer

COMPANY TOTALS:
Percentage of Replacement Policies Sold to Total Annual Sales ____%
Percentage of Replacement Policies Sold to Policies In Force ____%
(as of the end of the preceding calendar year)
Percentage of Lapsed Policies to Total Annual Sales _____%
Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX K

LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM NOTICE

IMPORTANT CONSUMER INFORMATION REGARDING THE TENNESSEE LONG-TERM CARE INSURANCE PARTNERSHIP PROGRAM

Some long-term care insurance [policies] [certificates] sold in Tennessee may qualify for the Tennessee Long-Term Care Insurance Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect the [policyholder's] [certificateholder's] assets through a feature known as "Asset Disregard" under TennCare, Tennessee's Medicaid program.

Asset Disregard means that an amount of the [policyholder's] [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership [Policy] [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership [Policy] [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance [policy] [certificate] that is not a Partnership [Policy] [Certificate]. Therefore, you should consider if Asset Disregard is important to you, and whether a Partnership Policy meets your needs. **The purchase of a Partnership Policy does not automatically qualify you for Medicaid.**

What are the Requirements for a Partnership [Policy] [Certificate]? In order for a [policy] [certificate] to qualify as a Partnership [Policy] [Certificate], it must, among other requirements:

- be issued to an individual on or after February 8, 2006;
- cover an individual who was a Tennessee resident when coverage first becomes effective under the policy;
- be a tax-qualified policy under § 7702(B)(b) of the Internal Revenue Code of 1986;
- meet stringent consumer protection standards; and
- meet the following inflation requirements:
    - For ages 60 or younger - provides compound **annual** inflation protection
    - For ages 61 to 75 -provides some level of inflation protection
    - For ages 76 and older - no purchase of inflation protection is required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your [policy] [certificate] qualifies as a Partnership [Policy] [Certificate].

What Could Disqualify a [Policy] [Certificate] as a Partnership Policy. Certain types of changes to a Partnership [Policy] [Certificate] could affect whether or not such [policy] [certificate] continues to be a Partnership [Policy] [Certificate]. If you purchase a Partnership [Policy] [Certificate] and later decide to make *any* changes, you should first consult with [carrier name] to determine the effect of a proposed change. In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your [policy] [certificate] as a Partnership [Policy] [Certificate], you would not receive beneficial treatment of your [policy] [certificate] under the Medicaid program of that state. The information contained in this disclosure is based on current Tennessee and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your [policy] [certificate] under Tennessee's Medicaid program.

(Rule 0780-01-61, Appendix K, continued)

Additional Information. If you have questions regarding long-term care insurance [policies] [certificates] please contact [carrier name.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Bureau of TennCare.

APPENDIX L

LONG-TERM CARE INSURANCE PARTNERSHIP STATUS DISCLOSURE NOTICE

IMPORTANT INFORMATION REGARDING YOUR [POLICY'S] [CERTIFICATE'S] LONG-TERM CARE INSURANCE PARTNERSHIP STATUS

This disclosure notice is issued in conjunction with your long-term care policy:

Some long-term care insurance [policies] [certificates] sold in Tennessee qualify for the Tennessee Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance [policies] [certificates] that qualify as Partnership [Policies] [Certificates] may be entitled to special treatment, and in particular an "Asset Disregard," under Tennessee's Medicaid program.

Asset Disregard means that an amount of the [policyholder's] [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership [Policy] [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership [Policy] [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $[500,000]. Asset Disregard is **not** available under a long-term care insurance [policy] [certificate] that is not a Partnership [Policy] [Certificate]. The purchase of this Partnership Policy does not automatically qualify you for Medicaid.

Partnership [Policy] [Certificate] Status**. Your long-term care insurance [policy] [certificate] is intended to qualify as a Partnership [Policy] [Certificate] under the Tennessee Long-Term Care Partnership Program as of your [Policy's] [Certificate's] effective date.**

What Could Disqualify Your [Policy] [Certificate] as a Partnership Policy**.** If you make any changes to your [policy] [certificate], such changes could affect whether your [policy] [certificate] continues to be a Partnership Policy. ***Before you make any changes, you should consult with [insert name of carrier] to determine the effect of a proposed change.*** In addition, if you move to a State that does not maintain a Partnership Program or does not recognize your [policy] [certificate] as a Partnership [Policy] [Certificate], you would not receive beneficial treatment of your [policy] [certificate] under the Medicaid program of that State. The information contained in this Notice is based on current State and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your [policy] [certificate] under Tennessee's Medicaid program.

Additional Information. If you have questions regarding your insurance [policy] [certificate] please contact [insert name of carrier.] If you have questions regarding current laws governing Medicaid eligibility, you should contact the Bureau of TennCare.

(Rule 0780-01-61, Appendix M, continued)

APPENDIX M

ISSUER CERTIFICATION FORM
(relating to Qualified State Long-Term Care Insurance Partnership)

Under Section 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)), the State insurance commissioner of a State implementing a qualified State long-term care insurance partnership ("Qualified Partnership") may certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy such requirements. These consumer protection requirements are set forth in Section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act" respectively).

In order to provide each State insurance commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requests information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

_____
_____
_____
_____

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

_____
_____
_____
_____

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

_____
_____
_____
_____

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. QUESTIONS REGARDING APPLICABLE PROVISIONS OF THE 2000 MODEL REGULATION AND 2000 MODEL ACT

Please answer each of the questions below with respect to the policy forms identified in Section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

Are the following requirements of the 2000 Model Regulation met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership that are issued on each of the policy forms identified in Section I.C above?

Yes ___ No ___ N/A ___ A. Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of Section 6B of the 2000 Model Act relating to such section 6A.

Yes ___ No ___ N/A ___ B. Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

Yes ___ No ___ N/A ___ C. Section 6C (relating to extension of benefits).

Yes ___ No ___ N/A ___ D. Section 6D (relating to continuation or conversion of coverage).

Yes ___ No ___ N/A ___ E. Section 6E (relating to discontinuance and replacement of policies).

Yes ___ No ___ N/A ___ F. Section 7 (relating to unintentional lapse).

Yes ___ No ___ N/A ___ G. Section 8 (relating to disclosure), other than Sections 8F, 8G, 8H, and 8I thereof.

Yes ___ No ___ N/A ___ H. Section 9 (relating to required disclosure of rating practices to consumer).

Yes ___ No ___ N/A ___ I. Section 11 (relating to prohibitions against post-claims underwriting).

Yes ___ No ___ N/A ___ J. Section 12 (relating to minimum standards).

Yes ___ No ___ N/A ___ K. Section 14 (relating to application forms and replacement coverage).

Yes ___ No ___ N/A ___ L. Section 15 (relating to reporting requirements).

Yes ___ No ___ N/A ___ M. Section 22 (relating to filing requirements for marketing).

Yes ___ No ___ N/A ___ N. Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of Section 23C.

Yes ___ No ___ N/A ___ O. Section 24 (relating to suitability).

Yes ___ No ___ N/A ___ P. Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(Rule 0780-01-61, Appendix M, continued)

Yes ___ No ___ N/A ___ Q. The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in Section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 U.S.C. 7702B(g)(4)).

Yes ___ No ___ N/A ___ R. Section 29 (relating to standard format outline of coverage).

Yes ___ No ___ N/A ___ S. Section 30 (relating to requirement to deliver shopper's guide).

Are the following requirements of the 2000 Model Act met with respect to all policies (including certificates issued under a group insurance contract) intended to be covered under the Qualified Partnership that are issued on each of the policy forms identified in section I.C above?

Yes ___ No ___ N/A ___ A. Section 6C (relating to preexisting conditions).

Yes ___ No ___ N/A ___ B. Section 6D (relating to prior hospitalization).

Yes ___ No ___ N/A ___ C. The provisions of Section 8 relating to contingent nonforfeiture benefits.

Yes ___ No ___ N/A ___ D. Section 6F (relating to right to return).

Yes ___ No ___ N/A ___ E. Section 6G (relating to outline of coverage).

Yes ___ No ___ N/A ___ F. Section 6H (relating to requirements for certificates under group plans).

Yes ___ No ___ N/A ___ G. Section 6J (relating to policy summary).

Yes ___ No ___ N/A ___ H. Section 6K (relating to monthly reports on accelerated death benefits).

Yes ___ No ___ N/A ___ I. Section 7 (relating to incontestability period).

In order for a policy to be covered under the Qualified Partnership of the State, the answers to all questions above should be "yes" (or "N/A" where all requirements with respect to a provision above are not applicable). If answers differ between policy forms (*e.g.*, a requirement would be answered "Yes" for one form and "N/A" for another), you should use separate Issuer Certification Forms for such policies.

III. CERTIFICATION

I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

_____ _____

Date Name and title of officer of the Issuer

_____

Signature of officer of the Issuer